Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

Brand-Name Multi-Source Drug
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Medicaid #: _____

DOB:_____ City: _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____NPI#: _____

Provider #:_____ City: _____ State: _____

Phone: _____ Fax: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact my subject me to civil penalties, fines or criminal prosecution.

_____ _____
Physician's Signature Date

PHARMACY INFORMATION

Dispensing Pharmacy:_____ Provider#:_____

City: _____State:_____ Phone#: _____

Fax#:_____

DRUG/CLINICAL INFORMATION

Drug Name & Strength: _____ Quantity/Month: _____

Daily dose: _____ NDC#: _____

Diagnosis:_____

DOCUMENTATION OF TRIAL OF GENERIC PRODUCT

Generic Product:_____ Manufacturer: _____

Length of therapy _____

Observed adverse reaction or allergic reaction:

_____

Documentation Included: Y☐ N☐ MedWatch Form Attached: Y☐ N☐

*MedWatch Form can be found at http://www.fda.gov/medwatch/safety/3500.pdf